Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2,688.20 for dates of service, 02/11/01, 02/18/01 and 03/02/01.

   b. The request was received on 02/26/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. Initial TWCC 60 and Letter Requesting Dispute Resolution
      1. UB-92s
      2. Medical Audit summary/EOB/TWCC 62 form
   b. Subsequent Submission of Information requested on 06/10/02 with fax confirmation: **No additional information received from Requestor.**
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor, with a copy to the insurance carrier Austin Representative, of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/10/02. There is no Carrier initial or 14 day response to this medical fee dispute in the file, evidently due to the fact no response to the 14 day notice was received from the Requestor.

III. PARTIES' POSITIONS

1. Requestor: Position Statement Letter undated
   "We tried our best to resolve this matter, but carrier keeps denying payment. This is why we are taking it to the Medical Dispute Resolution to get this issue resolve."

2. Respondent: No Position Statement

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 02/11/01, 02/18/01 and 03/02/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
02/11/01 02/18/01 02/18/01 03/02/01 03/02/01 03/02/02	72141 22 WP 73221 22 WP 72196 22 WP 92925 95900 95935	$924.00 $924.00 $924.00 $175.00 $179.20 $318.00	$756.00 $0.00 $0.00 $0.00 $0.00 $0.00	No EOB	$924.00 $924.00 $924.00 $175.00 $64.00/nerve $53.00	MFG MGR (IV); RGR ((II) ©; CPT Descriptor	On 05/05/01, the Carrier returned billing for these dates of service due to incomplete information. They requested copies of medical reports. No EOB is noted in the Requestor's packet to indicate additional information as requested was received and reviewed by the Carrier. The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed. There is no medical documentation for all dates of service in the file to support that services were rendered. Additionally, there are no HCFA 1500(s) for dates of service 02/11/01 and 02/18/01. **No** reimbursement is recommended
Totals		$3444.20	$756.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 12th day of August 2002.

Denise Terry, R.N.
Medical Dispute Resolution Officer
Medical Review Division

DT/dt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.